

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5984**
0877

FILED FEB 17 1955

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. _____

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Peoples Hospital		d. STREET ADDRESS (If rural, give location) 2119 1706 Belle Glade	
3. NAME OF DECEASED a. (First) EDWARD b. (Middle) _____ c. (Last) BECTON		4. DATE OF DEATH (Month) (Day) (Year) 1-25-55	
5. SEX MALE	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APRIL 29, 1905
9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 1 YEAR Hours _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (City and State or Foreign Country) MONEYS, MISS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME ISRAEL BECTON		13b. MOTHER'S MAIDEN NAME SUSIE WILSON	
14. NAME OF HUSBAND OR WIFE BERTRUDE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Bertrude Becton ADDRESS 1706 Belle Glade	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic glomerulonephritis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT (Specify) _____	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR _____		22. I hereby certify that I attended the deceased from Nov. 1954 to Jan. 25, 1955 that I last saw the deceased alive on 1/25, 1955 and that death occurred at 6:45 P.M. from the causes and on the date stated above.	
23a. SIGNATURE R. Williams, M.D. (Degree or title)		23b. ADDRESS 4701 A St. Louis	
23c. DATE SIGNED 1/28/55		24a. BURIAL, CREMATION, REMOVAL REMOVAL	
24b. DATE 1-27-55		24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK CEM	
24d. LOCATION (City, town, or county) (State) ST. LOUIS CITY MO		25. FUNERAL DIRECTOR'S SIGNATURE A.F. WALTON ADDRESS 2707 Stoddard St.	
DATE REC'D BY LOCAL REG. JAN 31 1955		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldin

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.